ENT OF CLAIM
PERSONAL INJURY PROTECTION BENEFITS

Liberty Mutual

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	FILE NO.
05/05/2003	LEONARD L. EGDAMIN	AO2-268-694568-01	05/02/2003	LA658-003558040-05

ASE COMPLETE AND RETURN THIS FORM TO US. YOUR COOPERATION WILL ENABLE US TO DETERMINE YOUR ELIGIBILITY FOR SONAL INJURY PROTECTION BENEFITS.

KIMBERLY BOYKIN
CLAIMS DEPARTMENT
Liberty Mutual Fire Insurance Company
PO Box 30608
Honolulu HI 96820

Tel: (808) 589-8920 / (800) 352-5957
Fax: (808) 589-8943

TIARA ENGLE
2623 NONOHE ST
WAHIAWA HI 96786-2842

NAME OF PERSON MAKING CLAIM	Phone No. HOME	BUSINESS
TIARA ENGLE	622-1138	622-1678
ADDRESS: 2623 NONOHE ST, WAHIAWA HI 96786-2842	DATE OF BIRTH: 06/04/1984	SOC. SEC. NO.: 576-27-4530

DATE AND TIME OF ACCIDENT	PLACE OF ACCIDENT (Street, City or Town and State)
05/02/2003 A.M. / P.M.	KAMEHAMEHA HIGHWAY, WAHIAWA, HI

DESCRIPTION OF ACCIDENT
I was a passenger in a vehicle driven by Brandon Egdamin. We were stopped at Whitmore Ave. waiting for the green light when Ms. Tautagaloa rearended our vehicle

AT THE TIME OF THE ACCIDENT WERE YOU (CHECK ONE)	AT THE TIME OF THE ACCIDENT WERE YOU A MEMBER OF THE POLICYHOLDER'S HOUSEHOLD?
THE DRIVER? ☐ A PASSENGER? ☒ A PEDESTRIAN? ☐	YES ☒ NO ☐

AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? ☒ YES ☐ NO IF YOUR ANSWER IS YES, COMPLETE THE REST OF THE FORM.
IF NO, SIGN HERE AND RETURN THIS FORM.

SIGNATURE: _____ DATE: _____

DESCRIPTION OF INJURY
Head, neck, back, arm pains, and other bodily injuries, as well as mental and emotional distress.

RE YOU TREATED BY A CTOR?	DATE OF 1ST TREATMENT	DOCTOR'S NAME AND ADDRESS
YES ☒ NO ☐	5/2/03	

IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN	HOSPITAL'S NAME AND ADDRESS
In-Patient? ☐ Out-Patient? ☒	Kaiser Moanalua

AMOUNT OF MEDICAL BILLS TO DATE: $	WILL YOU HAVE MORE MEDICAL EXPENSE?	AT THE TIME OF THIS ACCIDENT WERE YOU IN THE SCOPE OF YOUR EMPLOYMENT?
unknown	YES ☒ NO ☐	☐ YES ☒ NO

DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY?	IF YES, AMOUNT LOST TO DATE $	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? $
YES ☒ NO ☐	unknown	6.25./hr./$50/wk

IF YOU LOST WAGES: DATE DISABILITY FROM WORK BEGAN	DATE YOU RETURNED TO WORK
5/4/03	5/7/03

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR BENEFITS UNDER	YES	NO	IF YES, AMOUNT
(1) ANY WORKMEN'S COMPENSATION LAW?	☐	☒	
(2) EMPLOYMENT BY U.S. GOVERNMENT?	☐	☒	
(3) MILITARY SERVICE?	☐	☒	$ unknown (food stamps)
(4) WELFARE ASSISTANCE?	☒	☐	☐ PER WEEK ☐ MONTH
(5) SOCIAL SECURITY OR MEDICARE?	☐	☒	

LIST NAMES AND ADDRESSES OF YOUR EMPLOYERS AT THE DATE OF THE ACCIDENT AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

Chevron-1011 California Avenue, Wahiawa, HI 96786 -November 2002 to present

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? YES ☐ NO ☐ IF YES, EXPLAIN ON REVERSE SIDE

SIGNATURE: Tiara K. Engle DATE May 15, 2003

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSONS, FILES A STATEMENT OF CLAIM TAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT, MATERIAL RETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, SUBJECT TO CRIMINAL PROSECUTION AND CIVIL PENALTIES.

IMPORTANT:
1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST ALSO SIGN ANY ENCLOSED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE

FOR YOUR PROTECTION, HAWAII LAW REQUIRES YOU TO BE INFORMED THAT PRESENTING A FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT IS A CRIME PUNISHABLE BY FINES OR IMPRISONMENT, OR BOTH.

Helping People Live Safer, More Secure Lives

EXHIBIT B